POLICY OF STATE OF DELAWARE DEPARTMENT OF CORRECTION	POLICY NUMBER G-05	PAGE NUMBER 1 OF 12
	RELATED NCCHC/ACA STANDARDS: P-G-05, J-G-05, P-E-02, J-E-02, P-E-05, J-E-05, P-A-10/4-4373 (ESSENTIAL)	
CHAPTER: 11 HEALTH SERVICES	**SUBJECT:** SUICIDE PREVENTION, POLICIES AND PROCEDURES	
APPROVED BY THE COMMISSIONER:		
EFFECTIVE DATE: 11-19-07		

POLICY:

Each Facility will have a program that identifies and responds to suicidal inmates

PURPOSE:

To outline specific procedures designed to prevent suicide and harm resulting from intentional self-injurious behaviors and identify behaviors and characteristics in inmates at risk of suicide.

To delineate staff roles and responsibilities relative to the various aspects of suicide prevention.

To maintain a suicide prevention program that fulfills all of the standard requirements for suicide prevention in the correctional environment; including:

A. Training	F. Communication
B. Screening/Referral	G. Intervention
C. Assessment	H. Notification/ Reporting
D. Housing	I. Morbidity and Mortality Review
E. Observation	J. Critical Incident Debriefing

GENERAL CONSIDERATIONS:

1. There are critical periods and risk factors that may be indicative of increased suicide risk for some inmates. Such critical periods and risk factors include the first 24 hours of incarceration, arrival at prison, intoxication and/or substance abuse, acute or chronic mental illness, debilitating physical illness, isolation (segregation, single cell), long sentence, court proceedings (added charges, denied parole, unexpected outcome), significant loss (job, significant other, death), “bad news” (divorce, break-up, foreclosure),

significant position in community, feels unsafe in the facility, history of prior suicide attempts and/or self-injury, and juvenile status.

2. All staff has a role and responsibilities in the identification, referral, and management of suicidal and self-injurious behavior. However, it is the responsibility of mental health and medical staff to assess suicide risk, assigns level of risk/care, evaluate changes in the inmate's status, communicate specific information about the status of the risk to the appropriate multidisciplinary staff members, and provide clinically indicated treatment and follow-up. Such responsibilities do not end with the Intake period but continue through the entire period of incarceration.
3. Regular communication between medical and correctional staff regarding day-to-day observations of inmate behaviors and operations in housing units is an essential component in preventing inmate suicides.

PROCEDURE:

A. **Training:**

1. All staff (DOC and contractual) who have regular contact with inmates shall undergo an 8 hour initial, and two hour annual refresher, training in suicide prevention. Training will be in accordance with the curriculum entitled "Suicide Intervention and Prevention" provided by the DOC Office of Health Services (OHS) and Employee Development Center (EDC).
2. EDC shall maintain documented evidence of initial and annual suicide prevention training in every DOC employee's training file. The site Health Service Administrator shall maintain documented evidence of initial and annual suicide prevention training in every healthcare employee's training file.
3. All healthcare staff who have regular contact with inmates, including independent contractors and providers subcontracted, are expected to complete the above-referenced suicide prevention training.

4. Site administrators are responsible for ensuring all employees are made available to receive annual suicide prevention training courses at their designated sites, while it is the responsibility of OHS and EDC to provide the training.

B. **Screening/Referral**

1. All inmates shall be screened by qualified health care staff for potential signs and symptoms of suicide risk prior to placement in any housing unit and referred for mental health intervention, as appropriate, in accordance with the applicable DOC Policy on Receiving Screening-Intake Unit.

2. Healthcare services promote the use of inmate tracking systems to identify inmates with prior suicide risk issues.

3. Intake staff performing such screenings shall exercise prudent clinical judgment in assessing the risk of suicide and initiating mental health referrals. Staff should not rely exclusively on an inmate's denial that they are suicidal and/or have a history of mental illness and suicidal behavior, particularly when their behavior or previous confinement suggests otherwise.

4. Any inmate identified as potentially suicidal must remain under constant observation by custody staff in a safe cell while an order for placement on psychiatric observation is obtained from the appropriate medical/mental health personnel. Mental health staff shall evaluate as soon as possible, never to exceed 24 hours, any inmate identified as potentially suicidal. Mental health staff i.e. masters level, PHD or psychiatrist may initiate an order for psychiatric observation. However, only a PHD psychologist or psychiatrist may discharge or down grade an inmate on psychiatric observation.

5. Any staff member of the institution concerned that an inmate may be potentially suicidal is expected to inform mental health/medical staff immediately.

C. **Assessment**

1. Inmates with positive mental health screening results shall receive a mental health evaluation by a mental health professional in accordance with DOC policy on Mental Health Screening and Evaluation.
2. Evaluation of inmates by mental health staff will include but not be limited to assessment of:
    a. Mental status;
    b. Inmate's self-report of behavior resulting in the referral;
    c. Current suicide risk: active/passive ideation, plans, lethality of plan, recent stressors, goal of behavior;
    d. History of suicidal behavior/ideation: When, method used or contemplated, reason/triggering event for attempt, consequences of prior attempts/gestures;
    e. Inmate's report of his/her potential for suicidal behavior
    f. Inmate's willingness to verbally agree that he/she will not engage in self-injurious behaviors and will notify staff immediately if such feelings occur
3. Mental health staff will request a psychiatric consult whenever clinically indicated.
4. Inmates who continue to engage in self-injurious behaviors after placement in Suicide Precautions will be referred to the psychiatrist and considered for transfer to an inpatient psychiatric setting.

D. **Housing**

1. The Health Service Administrator and/or Mental Health Supervisor will work collaboratively with site correctional administration to facilitate appropriate housing for inmates placed on Suicide Precautions. Cells designated for such inmates should be made as *suicide-resistant* (i.e. a cell without protrusions that would provide easy access for a hanging attempt, that does not have furniture with sharp edges or loose pieces that could be used for cutting, that does not have an accessible electrical outlet, and that provides full visibility to staff) as is reasonably possible.

2. Prior to placement of an inmate in a suicide precautions cell, correctional staff are expected to conduct an inspection of the cell to ensure that it is free of items that may be used by the inmate to self-inflict injury.

3. Inmates on suicide precautions shall be permitted to have only items authorized according to their level of observation (see section E). Any additional restrictions/deviations will be specified by a mental health professional via a written order in the inmate's health care record. Such restrictions/deviations will take into consideration security concerns. The Warden or his/her designee will work with mental health to resolve any disputes with custody staff regarding the appropriate restrictions/privileges in a particular instance.

4. If the removal of clothing from a suicidal inmate is indicated, they shall be issued a suicide-resistant safety garment.

5. The use of chemical/physical restraints shall be avoided whenever possible and used only as a last resort, when the inmate is engaging in behavior that presents an imminent risk to self or others, and in accordance with the DOC policy titled Use of Clinical (Therapeutic) Restraints.

E. **Observation**

1. "Psychiatric Observation" is considered an observational status placed upon inmates deemed to be at risk for suicide or experiencing extreme decompensation and requiring increased surveillance and management by staff.

2. The Suicide Precautions-Psychiatric Observation plan includes three levels of observation as defined below:

   a. Level I- Constant Observation – Reserved for the inmate who is actively suicidal, either threatening or engaging in self-injurious behavior. These inmates must be housed in a cell designated as appropriate for Level I observation in accordance with Section D above. These inmates must be monitored by direct and continuous visual observation by correctional staff and documented on an observation sheet at least every 15 minutes. The observation log should be copied with one copy going

to the shift commander and one copy given to the nursing staff to be filed in the inmate's medical chart.

b. Level II- Close Observation – Reserved for the inmate who is not actively suicidal, but expresses suicidal ideation (i.e., expressing a wish to die without a specific threat or plan) and/or has a recent prior history of self-destructive behavior OR an inmate who denies suicidal ideation or does not threaten suicide, but demonstrates other behaviors suspicious for potential self-injury as noted by the inmate's actions, current circumstances, or recent history. This level of observation is also used for inmates who due to psychiatric decompensation are at risk of injury to self or others. These inmates must be housed in a cell designated as appropriate for Level I or II observation in accordance with Section D above. Documented observation intervals by correctional staff at staggered intervals, not to exceed every 15 minutes. The observation log should be copied with one copy going to the shift commander and one copy given to the nursing staff to be filed in the inmate's medical chart.

c. Level III-Close Observation- Reserved for the inmate who is not expressing suicidal ideation or severe decompensation but requires observation until further stabilized or has certain risk factors suggesting a higher potential for becoming severely decompensated and/or suicidal as compared to the inmate without such risk factors. These inmates must be housed in a cell designated as appropriate for Level I, II, or III observation in accordance with Section D above. Documented observation intervals by correctional staff are at staggered intervals, not to exceed every 15 minutes. The observation log should be copied with one copy going to the shift commander and one copy given to the infirmary nurse to be filed in the inmate's medical chart.

Restrictions and required actions under Level I, II, and III are indicated on the Mental Health/Psychiatry Observation Level Sheet (see Attachment A).

3. Other supervision aids, including closed circuit television monitoring, should only be considered for use as a supplement but never as a substitute for physical observation checks provided by staff.

4. Mental health staff or trained healthcare staff shall assess and interact with all inmates on Suicide Precautions on a daily basis. Each interaction with mental health staff is to be recorded in the progress record on a Psychiatric Observation Note form (see Attachment C).

    a. When an inmate is placed on any level of observation the referring mental health staff or the first mental health staff to see the inmate (if placed on observation through a verbal order) must complete:

        - An Initial Psychiatric Observation Note including a risk assessment and treatment plan (see Attachment B)
        - An order for placement on watch
        - The on the Mental Health/Psychiatry Observation Level Sheet, which is to be placed on cell door
        - Documentation of placement on observation on the problem list
        - Documentation of placement on observation in the observation log
        - Any memos or other notifications of observation status for custody/administration as required by local policy or procedure

    b. All inmates placed on any level of psychiatric observation must have a comprehensive mental health evaluation completed prior to their discharge from observation.

    c. A treatment plan for use after discharge will be developed or the current treatment plan updated for all inmates placed on suicide precautions

5. All inmates will receive a physical evaluation by a medical doctor as soon as possible, but not to exceed 24 hours, following placement on psychiatric observation. Ongoing medical observation will be provided by nursing staff, who will interact with inmates on psychiatric observation a minimum of one time per shift and document each interaction on a progress note.

6. Inmates on psychiatric observation can only be down graded or removed with the an order from a PHD psychologist or psychiatrist.

7. Inmates on any level of psychiatric observation shall be downgraded to the next lower level for a reasonable period of time (no less than 24 hours for each level) before being discharged from Suicide Precautions.

    a. The decision to continue or remove an inmate on psychiatric observation is optimally achieved following a multidisciplinary discussion among correctional and healthcare staff.

8. All inmates discharged from psychiatric observation shall receive regularly scheduled follow-up assessment by mental health staff for as long as is clinically indicated or as directed by the inmate's individual treatment plan. All assessments will be documented on approved progress note forms or in SOAP format in the inmate's medical record.

    a. Post-Psychiatric Observation assessment by mental health or trained healthcare staff is as follows:

        i. Within 24 hours of removal

        ii. Within seven days of removal or more frequently, if clinically indicated by the inmate's condition

        iii. Twenty-one to thirty days post-removal or more frequently, if clinically indicated by the inmate's condition

        iv. The site Mental Health Supervisor will ensure that a log is maintained to track post psychiatric observation visits

9. All inmates returning from the hospital for emergency or inpatient treatment following a suicide attempt/gesture will be admitted to the infirmary on Level I Observation until they receive an evaluation by mental health staff.

    a. During non-working hours, the healthcare professional performing the transfer assessment shall contact the on-call mental health professional for consultation and to determination if further precautions are required. This contact shall be documented by the healthcare professional in the inmate's medical record.

F. **Communication**

1. Medical staff is responsible for immediately notifying mental health supervisor regarding inmate suicide/self-injury events and placement of the inmate on Suicide Precautions. Notification shall be documented in the health care record.

2. The site Mental Health Supervisor shall ensure that a mental health professional is designated as "on-call" during non-working hours and that contact information for that individual(s) is made available to medical and custody staff.

3. The Health Service Administrator or his/her designee is responsible for overseeing maintenance of a daily roster of all inmates on Suicide Precautions and shall have a process for communicating this information to appropriate medical, mental health and correctional staff. The Observation Log is to be kept in an accessible location and maintained by all mental health staff doing rounds.

4. Regular communication between health care and correctional personnel regarding the current status of inmates on psychiatric observation will occur at a minimum of one time per shift; ideally during medical shift report and/or custody briefings. Procedure to facilitate such communication will be established locally at each facility.

5. As part of their daily interaction with and assessment of inmates on suicide precautions, mental health staff shall proactively seek input from the correctional officers regarding the inmate's behavior, mood, sleeping pattern, appetite, communication, as well as any other pertinent factors and document such on the daily psychiatric observation note.

6. Formal multidisciplinary case management meetings, including mental health, medical, and custody staff, shall be held on a weekly basis to discuss the status of all inmates on psychiatric observation. Information gathered from these meetings will be taken into consideration in the development of inmate treatment plans. It is the responsibility of the site Mental Health Supervisor to coordinate these meetings.

7. Should an inmate on observation require a transfer to an off-site facility or another correctional facility, a member of the healthcare staff (Mental Health Director, Health Service Administrator or their designees) will contact the warden or designee immediately and coordinate services.

G. **Intervention**

1. Healthcare staff will respond immediately and provide appropriate medical attention to any inmate who has attempted suicide or engaged in a self-injurious act in accordance with DOC Emergency Services policy.
    a. Hanging attempts will be handled in accordance with the procedure "Disposition Following a Hanging Attempt." (see Attachment D)
2. In accordance with site protocols, Mental Health staff shall be notified regarding any incidence of self-injury or suicide attempts.
    a. After the inmate's medical condition has been stabilized, mental health staff shall perform a clinical evaluation, including mental status, review of staff and inmate's report of self-injurious act, and inmate's risk of lethality.
    b. Based on the results of this evaluation, mental health staff will determine the need for further mental health and/or psychiatric intervention and will indicate the required level of suicide precaution.
3. When clinically indicated, administration of emergency psychotropic medication to suicidal inmates shall be in accordance with the DOC Emergency Psychotropic Medications policy.
4. Application of restraint, when clinically indicated, shall be in accordance with the DOC Use of Clinical (Therapeutic) Restraints policy.

H. **Notification/Reporting**

1. Notification and reporting of inmate death and/or suicide attempt will remain in accordance with the following DOC policies and procedures: Procedure In The Event of an Inmate Death and Morbidity and Mortality Review.
2. The healthcare staff who is notified first of a suicide or suicide attempt will immediately notify the Warden, Health Service Administrator or designee, and Site Mental Health Director.

3. The warden or designee is responsible for notifying the Director of the DOC Office Health Services or his/her designee, family members, and any applicable outside authority regarding attempted or completed suicides.

4. All medical and mental health staff who have relevant information regarding a suicide or suicide attempt (e.g. interaction with the inmate just prior to the incident, responder to the incident, etc.) shall provide input to the Health Service Administrator and/or Mental Health Director, as requested, regarding their knowledge of the victim and the incident and complete an incident report in DACS, prior to the end of their shift.

I. **Morbidity and Mortality Review**

1. The site Health Services Administrator will coordinate a morbidity and mortality review within 30 days of a completed suicide or a *serious suicide attempt*.

2. The review will be conducted in accordance with DOC Morbidity and Mortality Review policy and will include an inquiry of:

   a. the circumstances surrounding the incident;

   b. facility procedures relevant to the incident;

   c. relevant training received by staff involved;

   d. pertinent medical and mental health reports involving the victim;

   e. possible precipitating factors; and

   f. recommendations, if any, that are made.

3. A written plan shall be developed to address any identified areas requiring corrective action.

J. **Critical Incident Debriefing**

1. In the event of a serious suicide attempt or completed suicide, critical incident debriefing is available to all correctional and healthcare staff as well as inmates affected by the incident.

a. The site HSA and Mental Health Director shall collaborate with the Correctional Administrative staff to determine the facility's debriefing protocol.

2. Mental health staff will work collaboratively with the facility's designated debriefing team to ensure that information is made available to staff regarding the means to access to the designated employee assistance entity.

    a. Mental health staff will make available educational material regarding critical incident stress to affected staff and inmates.

    b. Affected inmates will be reminded of the process for requesting mental health services, in the event that they should need to do so in the future.

    c. Mental health staff does not provide ongoing psychological support services to healthcare or correctional staff.

3. For inmates in need of additional psychological services, mental health staff will perform a mental health evaluation and, when clinically indicated, develop a treatment plan to provide psychological and/or psychiatric services necessary to prevent psychological decompensation and promote optimal functioning of the inmate within the correctional environment.

4. For maximum effectiveness, the critical incident debriefing and other appropriate support services should be offered within 24 to 72 hours following the critical incident.

RELATED MATERIAL: NCCHC Standards P-G-05, J-G-05, P-E-02, J-E-02, P-E-05, J-E-05, P-A-10, DOC Suicide Intervention and Prevention Training Curriculum, and DOC policies on Receiving Screening-Intake Unit, Mental Health Screening and Evaluation, Use of Clinical (Therapeutic) Restraints, Emergency Services, Emergency Psychotropic Medications, Procedure In The Event Of An Inmate Death, and Morbidity and Mortality Review.

ATTACHMENT A

DOC

MENTAL HEALTH/PSYCHIATRY OBSERVATION LEVEL SHEET

Form to be posted on inmate's door and then filed in the medical chart when released from watch

Name: _____ SBI: _____ Location: _____

Date/Time: _____ Ordering Provider: _____

Nurse signature: _____

The authorized provider has ordered the patient to be placed on (Please circle level, housing recommendation, restrictions that apply, and backup recommendation):

LEVEL I (High Risk)	**LEVEL II (Moderate Risk)**	**LEVEL III (Low Risk)**
May or May not house alone	**May or May not house alone**	**May or May not house alone**
Isolation room Suicide gown All Restrictions No bed linen No sharps No personal items No pens/pencils No plastic bags No eating utensils OTHERS: _____	Isolation room Suicide gown All Restriction No bed linen No sharps No personal items No pens/pencils No plastic bags No eating utensils OTHERS: _____	Housed in infirmary DOC uniforms Some restrictions No sharps/razors No plastic bags Remove pens/ pencils when not in use OTHERS: _____
1:1 Observation 15 minute interval documentation Supervised bathing/ shaving	15 minute checks (staggered intervals no greater than 15 minutes) Supervised bathing/ shaving	15 minute checks (staggered intervals no greater than 15 minutes) Supervised bathing/ shaving
2/3 man back up YES/NO	**2/3 man back up YES/NO**	

A mental health evaluation is required to downgrade suicide level. A new sheet is required for each level change.

ATTACHMENT B

PSYCHIATRIC OBSERVATION NOTE – Initial Evaluation

Chart reviewed: ☐ Yes ☐ No **Status:** ☐ Inpatient ☐ Outpatient **Patient seen:** ☐ Office/Interview Room ☐ Cellside

Facility:_____ Housing Unit: _____ Interview Date: ___/___/_____Time:_____

Inmate's Name: _____ **ID#:** _____ **DOB:** ___ /___/_____

Reasons for placement on observation status and/or reason(s) for inmates attempt at suicide or self harm behavior:

_____

_____

Statement(s) of inmate:

_____

_____

Provider's observation of lethality risk factors:

Check any factors present and document:

- ☐ Active mental health symptoms:_____
- ☐ Current or past mental health treatment: _____
- ☐ Past or current history of self harm:_____

  _____
- ☐ Verbal threats of self harm or harm towards others:_____

  _____
- ☐ Change in legal status:_____
- ☐ First incarceration:_____
- ☐ Age:_____
- ☐ Recent losses or psycho-social changes:_____
- ☐ Family history of self harm or suicidal acts: _____

  _____
- ☐ Health changes: _____
- ☐ Change or lack of medication prior to incarceration:_____
- ☐ Accounts of the arresting or booking staff:_____
- ☐ Behavioral observations: _____
- ☐ Substance abuse history: _____

Clinical Observations:

_____

_____

_____

_____

Site: _____ **Inmate Name: _____** **SBI: _____**

Current Mental Status:

OBJECTIVE *:*

Appearance: ☐ Neat/clean ☐ Disheveled ☐ Well-nourished/developed ☐ Cooperative ☐ Uncooperative ☐ Hostile ☐ Oppositional ☐ Guarded

_____

Psychomotor: ☐ Normal ☐ Retarded ☐ Unsteady gait ☐ Tremor ☐ Abnormal movements ☐ Rigidity ☐ Restless ☐ Agitated ☐ Grimacing

_____

Speech: ☐ Normal ☐ Nonspontaneous ☐ Slowed ☐ Monotone ☐ Pressured ☐ Slowed ☐ Monotone ☐ Word finding difficulties
☐ Limited vocabulary ☐ Disorganized ☐ Dysarthria ☐ Dysphasia ☐ Mute ☐ Rapid ☐ Pressured

_____

Mood: ☐ Appropriate ☐ Stable ☐ Euthymia ☐ Depressed ☐ Irritable ☐ Anxious ☐ Fearful ☐ Euphoric

_____

Affect: ☐ Appropriate ☐ Depressed ☐ Angry ☐ Dysphoric ☐ Inappropriate ☐ Blunted ☐ Flat ☐ Expansive ☐ Tearful ☐ Anxious
☐ Confused ☐ Fearful ☐ Irritable

_____

Thought Process: ☐ Goal-directed ☐ Coherent ☐ Logical ☐ Circumstantial ☐ Tangential ☐ Looseness of Associations ☐ Thought Blocking ☐ Clang associations ☐ Neologisms ☐ Perseverations ☐ Rambling ☐ Flight of Ideas

_____

Thought Content: ☐ Appropriate ☐ Delusion ☐ Phobia ☐ Compulsion ☐ Obsessions ☐ Suicidal ideations ☐ Homicidal ideations
☐ Thought Broadcasting ☐ Thought Poverty ☐ Thought Control ☐ Ideas of Reference ☐ Paranoia
☐ Helplessness ☐ Hopelessness

_____

_____

Sensorium: ☐Awake ☐ Clouded ☐ Confused ☐ Stuporous ☐ Memory – Intact/Impaired

_____

Perception: ☐ Intact ☐ Hallucinations ☐ Auditory ☐ Visual ☐ Tactile ☐ Olfactory ☐ Gustatory ☐ Illusions

_____

Insight: ☐ Good ☐ Impaired **JUDGMENT:** ☐ Good ☐ Impaired

_____

Data regarding inmate behavior as reported by:

☐ Nursing:_____

☐ Custody:_____

☐ Other (_____):_____

Risk Assessment:

Is lethality an active issue? ☐ No ☐ Yes (If yes, check all that apply)

☐ Suicidal Ideation (describe):_____

☐ Suicide Plan (describe):_____

☐ Homicidal Ideation (describe):_____

This inmate appears to be at _____risk for injury to self or others based on this assessment.

Overall Assessment:

_____

_____

_____

_____

Site: _____ Inmate Name: _____ SBI: _____

Plan:

- ☐ Place psychiatric observation Level _____ due to:_____
- ☐ Begin treatment goals as checked below
- ☐ Inmate to be seen each shift by medical
- ☐ Inmate to have daily evaluation by mental health (M-F)
- ☐ Inmate to be evaluated by psychiatry for possible medication initiation or adjustment
- ☐ Observation status added to problem list in medical chart
- ☐ Request information/records from: _____
- ☐ Other:_____

Treatment Plan Goals and Objectives:

1. Goal: To remain free of suicidal/homicidal ideation, plan and/or intent

Objective: 1) Inmate will report any changes in lethality to security or CMS staff, 2) use effective coping skills as needed, 3) put in sick call to request mental health services as needed

Intervention:

☐ Mental Health Professional will meet with inmate on ___/___/_____ to re-assess and plan treatment as needed (must be within 1 business day)

2. Goal:_____

Objective:_____

Intervention_____

3. Goal:_____

Objective:_____

Provider's Signature/Title: _____ Date: ____/____/____ Time: _____

Site: _____ Inmate Name: _____ SBI: _____

ATTACHMENT C

PSYCHIATRIC OBSERVATION NOTE

Visit Type: [ ] Daily Visit [ ] Post-Release from Psychiatric Observation

Facility:_____ Housing Unit: _____ Interview Date: ___/___/_____Time:_____

Inmate's Name: _____ ID#: _____ DOB: ___/___/_____

Chart reviewed: ☐ Yes ☐ No **Status:** ☐ Inpatient ☐ Outpatient **Patient seen:** ☐ Office/Interview Room ☐ Cellside

Check One:

☐ Inmate is currently on Psychiatric Observation Level ____ in the Infirmary

☐ Inmate Released from Psychiatric Observation on ____/____/____

Statement(s) of inmate:

_____

_____

Current Mental Status:

OBJECTIVE :

Appearance: ☐ Neat/clean ☐ Disheveled ☐ Well-nourished/developed ☐ Cooperative ☐ Uncooperative ☐ Hostile ☐ Oppositional ☐ Guarded

_____

Psychomotor: ☐ Normal ☐ Retarded ☐ Unsteady gait ☐ Tremor ☐ Abnormal movements ☐ Rigidity ☐ Restless ☐ Agitated ☐ Grimacing

_____

Speech: ☐ Normal ☐ Nonspontaneous ☐ Slowed ☐ Monotone ☐ Pressured ☐ Slowed ☐ Monotone ☐ Word finding difficulties ☐ Limited vocabulary ☐ Disorganized ☐ Dysarthria ☐ Dysphasia ☐ Mute ☐ Rapid ☐ Pressured

_____

Mood: ☐ Appropriate ☐ Stable ☐ Euthymia ☐ Depressed ☐ Irritable ☐ Anxious ☐ Fearful ☐ Euphoric

_____

Affect: ☐ Appropriate ☐ Depressed ☐ Angry ☐ Dysphoric ☐ Inappropriate ☐ Blunted ☐ Flat ☐ Expansive ☐ Tearful ☐ Anxious ☐ Confused ☐ Fearful ☐ Irritable

_____

Thought Process: ☐ Goal-directed ☐ Coherent ☐ Logical ☐ Circumstantial ☐ Tangential ☐ Looseness of Associations ☐ Thought Blocking ☐ Clang associations ☐ Neologisms ☐ Perseverations ☐ Rambling ☐ Flight of Ideas

Thought Content: ☐ Appropriate ☐ Delusion ☐ Phobia ☐ Compulsion ☐ Obsessions ☐ Suicidal ideations ☐ Homicidal ideations ☐ Thought Broadcasting ☐ Thought Poverty ☐ Thought Control ☐ Ideas of Reference ☐ Paranoia ☐ Helplessness ☐ Hopelessness

_____

_____

Sensorium: ☐Awake ☐ Clouded ☐ Confused ☐ Stuporous ☐ Memory – Intact/Impaired

_____

Perception: ☐ Intact ☐ Hallucinations ☐ Auditory ☐ Visual ☐ Tactile ☐ Olfactory ☐ Gustatory ☐ Illusions

_____

Insight: ☐ Good ☐ Impaired **Judgment:** ☐ Good ☐ Impaired

_____

Other Objective Data: _____

_____

Site: _____ Inmate Name: _____ SBI: _____

Data regarding inmate behavior as reported by:

□ Nursing:_____

□ Custody:_____

□ Other (_____):_____

Overall Assessment:

_____

_____

_____

Lethality Assessment: Is lethality an active issue? □ No □ Yes (If yes, check all that apply)

□ Suicidal Ideation (describe):_____

□ Suicide Plan (describe):_____

□ Homicidal Ideation (describe):_____

Plan:

□ Continued psychiatric observation Level _____ due to:_____

□ Continue with treatment goals as checked below

□ Symptoms improved but requires continued observation. Downgrade to Level ____ Psychiatric Observation in Infirmary

□ Continue with treatment goals as checked below

□ Inmate is no longer considered a danger to self or others - Discontinue Psychiatric Observation

□ Cleared for General Population placement

□ Transfer to Mental Health Unit

□ Revise current treatment plan to include goals below

Treatment Plan Goals and Objectives:

4. Goal: To remain free of suicidal/homicidal ideation, plan and/or intent

Objective: 1) Inmate will report any changes in lethality to security or CMS staff, 2) use effective coping skills as needed, 3) put in sick call to request mental health services as needed

Intervention:

□ Mental Health Professional will meet with inmate on ___/___/_____ to re-assess and plan treatment as needed (must be within 1 business day while on observation or for a post release visit)

5. Goal:_____
   Objective:_____
   Intervention_____

6. Goal:_____
   Objective:_____
   Intervention:_____

Provider's Signature/Title: _____ Date: ____/____/_____

Site: _____ Inmate Name: _____ SBI: _____

ATTACHMENT D

DISPOSITION FOLLOWING A HANGING ATTEMPT

1. Extricate inmate, protecting head and neck as much as possible.
2. Have someone call medical clinic immediately.
3. Give basic first aid
   - A. Monitor and maintain open airway
     1. Look, listen and feel for breathing, if unconscious.
     2. Maintain airway, if necessary, using the modified jaw thrust technique.

     DO NOT tilt the head back.
        a. Place your fingers behind the angles of the lower jaw
        b. Bring the jaw forward
        c. Use your thumbs to pull lower lip down to allow breathing through the mouth.
   - B. If there is no pulse, give cardiopulmonary resuscitation.
   - C. Assume the inmate has spinal cord injury and treat appropriately.
     1. Place inmate flat on floor with head held stable
     2. Do not let inmate or anyone else lift or twist inmate's head
     3. Do not give inmate anything to eat or drink, or any medication
   - D. If there is swelling or discoloration, apply an ice bag to the area.
   - E. Do not leave inmate alone.
     4. Provide medical care prior to mental health involvement.

Never leave inmate unattended until suicide precaution procedures have been implemented.